COLORADO MANDATORY DISCLOSURE STATEMENT

Michelle Hines MS, L.Ac RN
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970.493.0025
www.integrativeacupunctureclinic.com

Please read the following and sign below after you have had any questions answered and have understood this statement to your satisfaction.

Fee Schedule
Payment is due at the time of service. If your insurance does not cover this service, there is a time of service discount applied.

Michelle Hines and Holly Rampone-Gulder earned their Master of Science in Acupuncture from The Colorado School of Traditional Chinese Medicine. This program consists of 2,265 hours of education and 525 hours of clinical practice. Michelle and Holly's training includes other therapies such as: cupping, Tui Na massage, TCM nutrition (dietary/lifestyle recommendations), moxibustion, auriculotherapy, electro-stimulation and guasha. Both practitioners are currently earning their Doctoral degrees in Acupuncture. They are Licensed Acupuncturists in the State of Colorado and certified in Clean Needle Technique and Injection Therapy, CPR/First Aid and received their certification in Acupuncture through the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). They are members of the Acupuncture Association of Colorado & the American Association of Acupuncture and Oriental Medicine. None of their licenses or certifications has ever been suspended or revoked.

Any services offered by an employee at Integrative Acupuncture Clinic are not intended to substitute for those offered by a licensed medical doctor when needed. Referrals are made for further workup and treatment when appropriate. Patients may seek a second opinion from other health care practitioners or terminate therapy at any time. The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office,1560 Broadway, Suite 1350, Denver, Colorado 80202; (303) 894-7800.
I have read and understand this document, have had an opportunity to have any and all questions answered on the subject, and freely seek the services offered.

_____ _____

Patient's or Guardian's Signature *Date*

OFFICE POLICIES

Cancellations & missed appointments. Please provide **24-hour notice** of cancellation prior to your scheduled appointment. If you miss an appointment or cancel within 24 hours you will be charged a $50 fee and payment is required before you may schedule another appointment with us.

Reasons for being dismissed/denied treatment: Patients who show inappropriate conduct, non-or-late payment of fees, multiple no shows or late cancels, or safety concerns may be denied treatment. IAC reserves the right to refuse or dismiss services for any reason at any time.

FINANCIAL POLICY

Your payment is due in full at the time of service. For your convenience, we accept cash, check or credit cards (Visa or MasterCard only). For checks returned to us as unpaid by your bank, you will be charged a $30 fee.

INSURANCE POLICY

Many insurance companies cover acupuncture and most HSA cards are accepted! We are happy to verify coverage and check benefits for you; although we encourage you to verify your own benefits as well. If you have insurance that covers acupuncture we will submit your claims for you. You are responsible for your deductible, co-payment, and any non-covered or excluded amounts under your policy. If your insurance denies payment of a claim *you are responsible for billed charges*. In the case that your insurance company sends a check directly to you for the payment of the treatment, you hereby agree to endorse the check to Integrative Acupuncture Clinic and turn over payment with the accompanying Explanation of Benefits form.

RECORDS RELEASE & ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information to claims for benefits submitted. I further agree and authorize Holly Rampone-Gulder, L.Ac. and/or Michelle Hines L.Ac to submit claims for benefits, for services rendered, without obtaining my signature on each claim. **I understand that I am financially responsible for all charges incurred, whether or not they are covered by my insurance company.** This authorization shall remain valid until written notice is given by me revoking said authorization.

Please indicate your understanding and acceptance of these policies by signing below.

_____	_____	_____
Patient's Signature	*Patient's Name*	*Date*

970.493.0025 · 140 W. Oak Street, Suite 110 Ft. Collins, CO 80524 · www.integrativeacupunctureclinic.com

Consent to Treatment

By signing below, I do hereby authorize Michelle Hines and/or Holly Rampone-Gulder, Licensed Acupuncturists at INTEGRATIVE ACUPUNCTURE CLINIC to administer any style of Oriental Medicine relevant to my diagnosis and treatment, including but not limited to the following:

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Moxibustion: I understand that heat treatments using Artemesia vulgaris ("moxa") involves putting moxa on the head of a needle while inserted in the skin, or directly on the skin. The heat generated from moxa treatments may involve a slight discomfort or leave a blister or scar on the skin. I understand that I may refuse this therapy.

Chinese Herbs: I understand that Chinese Herbal formulas may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, or abdominal pain or discomfort. *Should I experience any problems which I associate with these substances, I should suspend taking them and call* Integrative Acupuncture Clinic *as soon as possible.*

Cupping: I understand that cupping may be used to promote circulation of qi though the meridians. Cups may produce a red/purple color on the area treated lasting for 1 – 5 days.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Most conditions require an average of 6-12 treatments, although some will respond within 4-6 treatments and others may require a longer series – this depends on the severity and the chronic nature of the chief complaint.

I have been informed that I have the right to refuse any form of treatment. I understand the nature of the treatment, have been informed of the risks and possible consequences involved in the treatment, and have been given an opportunity to ask questions pertaining to the treatment. I also understand that there is always a possibility of an unexpected complication and I understand that no guarantee can be made concerning the results of treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I understand that acupuncturists practicing in the state of Colorado are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ Date: _____

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Acknowledgment of Notice of Privacy Practices and Consent to Treat

With my consent, Integrative Acupuncture Clinic may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Integrative Acupuncture Clinic's **Notice of Privacy Practices** for more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

With my consent, Integrative Acupuncture Clinic may call my home or any other designated location and leave a message on my voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Integrative Acupuncture Clinic may mail to my home or other designated location any items that assist the practice carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked as personal and confidential.

With my consent, Integrative Acupuncture Clinic may email me appointment reminders and patient's statements. I have the right to request that Integrative Acupuncture Clinic restrict how it uses or discloses my PHI to carry out TPO.

By signing this form, I am consenting to Integrative Acupuncture Clinic's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Integrative Acupuncture Clinic may decline to provide treatment to me.

FOR TERMINAL CONDITIONS: In the event that my physician has advised me that I have a terminal illness, and that while my life may be prolonged for some period, my health cannot be restored or my disease cured. I understand that care given by the practitioners at *Integrative Acupuncture Clinic* is not directed to extending the length of life or reversal of disease from which I am suffering; which has been diagnosed by my physician as terminal. This supportive care is given to alleviate pain, suffering or other symptoms in the efforts to keep me comfortable. In the event of a medical emergency, standard emergency protocols will be rendered. With full knowledge of the above facts, I consent my care and treatment under the above conditions, and I hereby release *Integrative Acupuncture Clinic* and its independent contractors from all liability in following my wishes that care in the program be limited to that care outlined above, which is aimed at relieving my symptoms and making me comfortable. Please indicate if you have a DNR (do not resuscitate). *(Initials:_____)*

I, _____, hereby acknowledge that I read and reviewed a copy of Integrative Acupuncture Clinic's Notice of Privacy Practices and fully understand this consent form. I am consenting to the use and/or disclosure of my health information to treat me and arrange for my medical care. I am consenting to be treated and am free to change my mind at any time about the method of care.

_____ _____

Signature of Patient or Parent/Legal Guardian *Date*